EXHIBIT B

APPROVED OMB 0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

SHEETMETALS WRAP AROUND P
COMBINED INS
P O BOX 1449
GOODLETTSVILLE TN 37070-1449

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY: 03 21 37 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 37 SPRING ST

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: AGAWAM STATE: MA

ZIP CODE: 01001 TELEPHONE (Include Area Code)

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 01001 TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 03 21 37 SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 03 21 37 SEX: M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE - MA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE SIGNED 11/23/01 DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE SIGNED

14. DATE OF CURRENT: MM DD YY ** ** ** ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: CHAUHAN,KIRAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185
2. 607.84
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 19 01	10 19 01	11	1	99214	25	1 2	125 00	1				
2 10 19 01	10 19 01	11	9	99202		1 2	1350 00	3				
3 10 19 01	10 19 01	11	1	96400		1 2	25 00	1				
4 10 19 01	10 19 01	11	5	31000		1 2	17 00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 04-2499982 EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: 1517 00

29. AMOUNT PAID: $ 1231 40

30. BALANCE DUE: $ 285 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

DAVID M CHADBOURNEMD

SIGNED DATE 11/23/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # 413 596 6618

UROLOGY GROUP OF WNE
PO BOX 489
WILBRAHAM MA 01095

PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

790-0116 (12/90) (OCR) 1 pt.

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M11346
CHECK/EFT #:125200135 11/09/01

125200135 100000216
UROLOGY GROUP OF WESTER
PAGE #: 3 OF 9

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]								ICN 0201303413360 ASG		Y MOA MA01 MA18	
N51765	1023 102301	11	1	99213		75.00	53.10	0.00	10.62 CO-42	21.90	42.48
N51765	1023 102301	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	10.62			CLAIM TOTALS		92.00	57.47	0.00	10.62	34.53	46.85
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											46.85 NET
[redacted]								ICN 0201303413490 ASG		Y MOA MA01 MA07	
N51765	1023 102301	11	1	99243		200.00	123.30	0.00	24.66 CO-42	76.70	98.64
PT RESP	24.66			CLAIM TOTALS		200.00	123.30	0.00	24.66	76.70	98.64
											98.64 NET
[redacted]								ICN 0201303316360 ASG		Y MOA MA01	
J08569	1016 101601	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
J08569	1016 101601	11	1	87086		25.00	11.16	0.00	0.00 CO-42	13.84	11.16
PT RESP	0.00			CLAIM TOTALS		42.00	15.53	0.00	0.00	26.47	15.53
											15.53 NET
[redacted]								ICN 0201303316740 ASG		Y MOA MA01	
N[redacted]	[redacted]		1	87184		25.00	9.53	0.00	0.00 CO-42	15.47	9.53
PT RESP	0.00			CLAIM TOTALS		25.00	9.53	0.00	0.00	15.47	9.53
											9.53 NET
[redacted]								ICN 0101289078290 ASG		Y MOA MA01 MA18	
N51765	1003 100301	11	1	61720		510.00	510.00	0.00	102.00		408.00
N51765	1003 100301	11	10	J9214		1500.00	129.80	0.00	25.96 CO-42	1370.20	103.84
N51765	1003 100301	11	1	J9031		170.00	166.49	0.00	33.30 CO-42	3.51	133.19
N51765	1003 100301	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
N51765	1003 100301	11	1	87086		25.00	0.00	0.00	0.00 CO-50	25.00	0.00
REM: M25											
PT RESP	161.26			CLAIM TOTALS		2222.00	810.66	0.00	161.26	1411.34	649.40
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											649.40 NET
[redacted]								ICN 0201303316310 ASG		Y MOA MA01 MA07	
A22764	1019 101901	11	1	99214		[redacted]	82.75	0.00	16.55 CO-42	42.25	66.20
A22764	1019 101901	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	16.55			CLAIM TOTALS		142.00	87.12	0.00	16.55	54.88	70.57
											70.57 NET
[redacted]								ICN 0201303413040 ASG		Y MOA MA01	
J08569	1022 102201	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	0.00			CLAIM TOTALS		17.00	4.37	0.00	0.00	12.63	4.37
											4.37 NET
[redacted]								ICN 0201303413370 ASG		Y MOA MA01 MA18	
N51765	1023 102301	11	1	53620		520.00	0.00	0.00	0.00 CO-815	520.00	0.00
REM: M80											
N51765	1023 102301	11	1	52000	59	280.00	196.71	0.00	39.34 CO-42	83.29	157.37
N51765	1023 102301	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	39.34			CLAIM TOTALS		817.00	201.08	0.00	39.34	616.92	161.74
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											161.74 NET
[redacted]											
[redacted]			1	99214	25	125.00	82.75	0.00	16.55 CO-42	42.25	66.20
[redacted]			3	J9202		1350.00	1339.47	0.00	267.89 CO-42	10.53	1071.58
[redacted]			1	96400		25.00	5.81	0.00	1.16 CO-42	19.19	4.65
J08569	1019 101901	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	285.60			CLAIM TOTALS		1517.00	1432.40	0.00	285.60	84.60	1146.80
											1146.80 NET
[redacted]								ICN 0201303413510 ASG		Y MOA MA01 MA18	
N51765	1023 102301	11	1	99213		75.00	53.10	0.00	10.62 CO-42	21.90	42.48
N51765	1023 102301	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	10.62			CLAIM TOTALS		92.00	57.47	0.00	10.62	34.53	46.85
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											46.85 NET
[redacted]								ICN 0201303412670 ASG		Y MOA MA01 MA18	
A21478	1023 102301	11	1	99214	25	125.00	82.75	0.00	16.55 CO-42	42.25	66.20
A21478	1023 102301	11	1	60050		50.00	37.70	0.00	7.54 CO-42	12.30	30.16
A21478	1023 102301	11	1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	24.09			CLAIM TOTALS		192.00	124.82	0.00	24.09	67.18	100.73
											100.73 NET

REDACTED

Sheetmetal

COPY

[redacted] 38

[redacted] Employee

04-3249509 51943

REDACTED

10/01/2001
Date Issued

Amount Paid: $266.78

REDACTED

SPRINGFIELD, MA 01101

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1556382** Check No. **0078924**

Explanation of Benefits **SMW+ Program**

[redacted]

08/03/2001	08/03/2001	$1,410.00	$0.00	$266.78	$266.78	$266.78

[redacted]

Comments:

REDACTED

[redacted]

PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR DR
STE 308
SPRINGFIELD, MA 01107

Provider: PIONEER VALLEY UROLOGY PC
Participant SSN:
CLV Claim Number: 1556382

Processed by *Southern Benefit Administrators, Inc.*

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SHEET METAL WORKERS
NATIONAL HEALTH TURST FD.
P.O. BOX 1449
GOODLETTSVILLE TN 37070-1

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA | MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) | PICA

1. (File #)

3. PATIENT'S BIRTH DATE MM DD YY: 08 14 18 | SEX: M [X] F [ ]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

SPRINGFIELD | MA

ZIP CODE: 01104 | TELEPHONE (Include Area Code): (413) 732-3268

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

TO ACCIDENT? YES [ ] NO [X] PLACE (State)

OTHER ACCIDENT? YES [ ] NO [X]

RETIRED

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE PART B CLAIMED

10d. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/28/01

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL DRESS, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D83074

19. RESERVED FOR LOCAL USE

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L185.
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

[redacted]

RETIRED

11. INSURED'S POLICY GROUP OR FECA NUMBER: RETIRED

11a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [X] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME: RETIRED

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES .00

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	08 03 01	3	1	99213		1	60.00	1.0				
2	08 03 01	3	1	J9202		1	1275.00	3.0				
				NDC00310096130								
3	08 03 01	3	1	96400		1	55.00	1.0				
4	08 03 01	3	5	81000		1	20.00	1.0				
5												
6												

25. FEDERAL TAX I.D. NUMBER: 043249509239 1 | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 51943

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1410.00

29. AMOUNT PAID: $ 1071.50

30. BALANCE DUE: $ 266.78

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J MICHAEL DECENZO, M.D

SIGNED 08/28/01 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE# (413) 784-8080

PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR.DR. STE.308
SPRINGFIELD MA 01107-1280

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500,

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M16033
CHECK/EFT #:124987431 08/20/01

124987431 100000268
PIONEER VALLEY UROLOGY PC
PAGE #: 10 OF 10

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]								ICN 0201219424810 ASG		Y MOA MA01	MA18
J08438	0802	080201	11	1	99212	40.00	37.94	0.00	7.59 CO-42	2.06	30.35
J08438	0802	080201	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
PT RESP	7.59				CLAIM TOTALS	60.00	42.31	0.00	7.59	17.69	34.72
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											34.72 NET
NAME											MA19
N51618	0803	080301	11	1	99213	60.00	53.10	0.00	10.62 CO-42	6.90	42.48
N51618	0803	080301	11	3	J9202	1275.00	1275.00	0.00	255.00		1020.00
N51618	0803	080301	11	1	96400	55.00	5.81	0.00	1.16 CO-42	49.19	4.65
N51618	0803	080301	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
PT RESP	266.78				CLAIM TOTALS	1410.00	1338.28	0.00	266.78	71.72	1071.50
											1071.50 NET
[redacted]								ICN 0201219424850 ASG		Y MOA MA01	MA18
H21069	0801	080101	11	1	99213	60.00	53.10	0.00	10.62 CO-42	6.90	42.48
H21069	0801	080101	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
PT RESP	10.62				CLAIM TOTALS	80.00	57.47	0.00	10.62	22.53	46.85
CLAIM INFORMATION FORWARDED TO: EMPIRE BC/BS											46.85 NET
[redacted]								ICN 0201219424840 ASG		Y MOA MA01	MA18
N51618	0801	080101	11	1	99213	60.00	53.10	0.00	10.62 CO-42	6.90	42.48
N51618	0801	080101	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
PT RESP	10.62				CLAIM TOTALS	80.00	57.47	0.00	10.62	22.53	46.85
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											46.85 NET
[redacted]								ICN 0201220519780 ASG		Y MOA MA01	MA18
N51618	0803	080301	11	1	99213	60.00	53.10	0.00	10.62 CO-42	6.90	42.48
N51618	0803	080301	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
PT RESP	10.62				CLAIM TOTALS	80.00	57.47	0.00	10.62	22.53	46.85
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											46.85 NET
[redacted]								ICN 0201219424860 ASG		Y MOA MA01	MA18
N51618	0801	080101	11	1	99213 25	60.00	53.10	0.00	10.62 CO-42	6.90	42.48
N51618	0801	080101	11	1	81000	20.00	4.37	0.00	0.00 CO-42	15.63	4.37
N51618	0801	080101	11	1	87088	30.00	11.18	0.00	0.00 CO-42	18.82	11.18
N51618	0801	080101	11	1	60050	100.00	37.70	0.00	7.54 CO-42	62.30	30.16
PT RESP	18.16				CLAIM TOTALS	210.00	106.35	0.00	18.16	103.65	88.19
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											88.19 NET

TOTALS	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL RC-AMT	TOTAL PROV PD
	99	26870.00	18449.62	406.20	3526.76	8420.38	14516.66

ADJS:	TOTAL PREV PD	TOTAL PD TO BENE	TOTAL INT	TOTAL MSP	TOTAL OFFSET	TOTAL OTHER ADJS	AMOUNT OF CHECK
	0.00	0.00	0.00	0.00	0.00	0.00	14516.66

GLOSSARY: Group, Reason, MOA, Remark and Offset Codes

CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
PR	Patient Responsibility. Amount that may be billed to a patient or another payer.
B15	Claim/service denied/reduced because this procedure/service is not paid separately.
B6	This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
42	Charges exceed our fee schedule or maximum allowable amount.
46	This (these) service(s) is (are) not covered.
M80	We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.
MA07	The claim information has also been forwarded to Medicaid for review.
MA15	Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA27	Incorrect entitlement number shown on the claim. Please use the entitlement number shown on this notice for future claims for this patient.
MA67	Correction to a prior claim.

REDACTED

SEP 10 2001

AUG 23 2001

REDACTED Employee

04-2499982

43

10/12/2001
Date Issued

Amount Paid: $285.60

REDACTED

AGAUAM, MA 01001

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1571547**

Check No. **0094183**

Explanation of Benefits **SMW+ Program**

[redacted]						
07/13/2001	07/13/2001	$1,517.00	$0.00	$285.60	$285.60	$285.60

[redacted]

Comments:

[redacted]

UROLOGY GRP OF WESTERN NEW
ENGLAND PC
PO BOX 489
WILBRAHAM, MA 01095

Provider: UROLOGY GRP OF WESTERN NEW
Participant SSN:
CDP Claim Number: 1571547

REDACTED

Processed by *Southern Benefit Administrators, Inc.*

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

SHEETMETALS WRAP AROUND P
COMBINED INS
P O BOX 1449
GOODLETTSVILLE TN 37070-1449

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

[redacted]

PATIENT'S BIRTH DATE: 03 21 37 SEX: M [X] F [ ]

[redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: AGAWAM STATE: MA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 01001

[redacted]

a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

[redacted]

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]
b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)
c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: 03 21 37 SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: 03 21 37 SEX: M [X] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE - MA

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE 08/16/01
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: CHAUHAN, KIRAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 185
2. 607.84
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 13 01	07 13 01	11	1	99214	25	1 2	125 00	1				
2 07 13 01	07 13 01	11	9	99202		1	1350 00	3				
3 07 13 01	07 13 01	11	1	96400		1 2	25 00	1				
4 07 13 01	07 13 01	11	5	81000		1 2	17 00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER: 04-2499982 SSN [ ] EIN [X]

26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 1517 00

29. AMOUNT PAID: $ 1231 40

30. BALANCE DUE: $ 285 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
DAVID M CHADBOURNE MD
SIGNED DATE 08/16/01

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
UROLOGY GROUP OF UNI
PO BOX 489
WILBRAHAM MA 01095
PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

790-0116 (12/90) (OCR) 1 pt.

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Qlicln 1-211-T MrR

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M11346
CHECK/EFT #:124946711 08/03/01

124946711 100000160
UROLOGY GROUP OF WESTER
PAGE #: 4 OF 8

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME [redacted]											
J08569	0705 070501 11		1	51720		510.00	209.66	0.00	41.93 CO-42	300.34	167.73
J08569	0705 070501 11		1	J9031		170.00	166.49	0.00	33.30 CO-42	3.51	133.19
J08569	0705 070501 11		1	96400		25.00	5.81	0.00	1.16 CO-42	19.19	4.65
J08569	0705 070501 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	76.39			CLAIM TOTALS		722.00	386.33	0.00	76.39	335.67	309.94
											309.94 NET

BC/BS

NAME [redacted]											
J08570	0713 071301 11		1	99211		39.00	21.31	0.00	4.26 CO-42	17.69	17.05
J08570	0713 071301 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	4.26			CLAIM TOTALS		56.00	25.68	0.00	4.26	30.32	21.42
CLAIM INFORMATION FORWARDED TO: JOHN HANCOCK											21.42 NET

NAME [redacted]											
N51765	0713 071301 11		1	52000		280.00	196.71	0.00	39.34 CO-42	83.29	157.37
PT RESP	39.34			CLAIM TOTALS		280.00	196.71	0.00	39.34	83.29	157.37
											157.37 NET

NAME [redacted]										NOA MA01	MA18
A21478	0619 061901 11		1	51720		510.00	209.66	0.00	41.93 CO-42	300.34	167.73
A21478	0619 061901 11		50	J9214		750.00	575.00	0.00	115.00 CO-42	175.00	460.00
PT RESP	156.93			CLAIM TOTALS		1260.00	784.66	0.00	156.93	475.34	627.73
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											627.73 NET

NAME [redacted]										NOA MA01	MA18
J08569	0709 070901 11		1	51720		510.00	209.66	0.00	41.93 CO-42	300.34	167.73
J08569	0709 070901 11		1	J9031		170.00	166.49	0.00	33.30 CO-42	3.51	133.19
J08569	0709 070901 11		1	96400		25.00	5.81	0.00	1.16 CO-42	19.19	4.65
J08569	0709 070901 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	76.39			CLAIM TOTALS		722.00	386.33	0.00	76.39	335.67	309.94
											309.94 NET

NAME [redacted]											
N51765	0713 071301 11		1	99213		75.00	53.10	0.00	10.62 CO-42	21.90	42.48
N51765	0713 071301 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	10.62			CLAIM TOTALS		92.00	57.47	0.00	10.62	34.53	46.85
											46.85 NET

Tufts

NAME [redacted]											
J08569	0713 071301 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	0.00			CLAIM TOTALS		17.00	4.37	0.00	0.00	12.63	4.37
											4.37 NET

REDACTED

NAME [redacted]						ICN 0201204537180 ASG				Y NOA MA01	
[redacted]	0713 071301 11		1	99214	25	1350.00	1339.47	0.00	267.89 CO-42	42.25	66.20
[redacted]	0713 071301 11		3	J9202		25.00	5.81	0.00	1.16 CO-42	19.19	4.65
[redacted]	0713 071301 11		1	96400		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
[redacted]	0713 071301 11		1	81000		1517.00	1432.40	0.00	285.60	84.60	1146.80
PT RESP	285.60			CLAIM TOTALS							1146.80 NET

Sheetm

NAME [redacted]											MA18
J08570	0613 061301 11		1	51720		510.00	0.00	0.00	0.00 CO-B15	510.00	0.00
J08570	0613 061301 11		50	J9214		750.00	0.00	0.00	0.00 CO-50	750.00	0.00
REM: M25											
J08570	0613 061301 11		1	J9031		170.00	152.29	0.00	30.46 CO-42	17.71	121.83
J08570	0613 061301 11		1	81000		17.00	4.37	0.00	0.00 CO-42	12.63	4.37
PT RESP	30.46			CLAIM TOTALS		1447.00	156.66	0.00	30.46	1290.34	126.20
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											126.20 NET

NAME [redacted]											
A21478	0716 071601 11		1	51726		375.00	219.56	0.00	43.91 CO-42	155.44	175.65
A21478	0716 071601 11		1	51797	51	520.00	108.36	0.00	21.67 CO-42	303.28	86.69
									CO-59	108.36	
A21478	0716 071601 11		1	60002	51	130.00	61.95	0.00	12.39 CO-42	6.11	49.56
									CO-59	61.94	
PT RESP	77.97			CLAIM TOTALS		1025.00	389.87	0.00	77.97	635.13	311.90
											311.90 NET

NAME RANDALL, DONALD		HIC 021166347A		ACNT 026686001		ICN 0201204537130 ASG				Y NOA MA01	MA18
A22764	0713 071301 11		1	99212		55.00	37.94	0.00	7.59 CO-42	17.06	30.35
PT RESP	7.59			CLAIM TOTALS		55.00	37.94	0.00	7.59	17.06	30.35
CLAIM INFORMATION FORWARDED TO: AETNA											30.35 NET

COPY

REDACTED

RELATIONSHIP: E

PROVIDER TAX I.D. #: 043249509

PATIENT ACCOUNT #: 40

NO 0585395

12/18/2002

DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

REDACTED

PAY ********263DOLLARS AND 86CENTS** DOLLARS $ ****263.86**

TO THE ORDER OF

PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR DR
STE 308
SPRINGFIELD , MA 01107

0585395

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37230

⑈00585395⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
11/08/2002	11/08/2002	1390.00	.00	263.86	263.86	263.86
		1390.00	.00	263.86	263.86	263.86

NON-COVERED CODES:

COMMENTS:

REDACTED

PROVIDER: PIONEER VALLEY UROLOGY PC
PARTICIPANT SSN: 034-05-5779 DEPENDENT: JEROME 01
CLM CLAIM NUMBER: 2001936

SPRINGFIELD MA 01101

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

SHEET METAL WORKERS
NATIONAL HEALTH TURST FD.
P.O. BOX 1449
GOODLETTSVILLE TN 37070-1

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

[redacted]

RAM IN ITEM

3. PATIENT'S BIRTH DATE: 08 14 14 SEX: M [X] F [ ]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: SPRINGFIELD STATE: MA

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

ZIP CODE: 01104

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

10. IS PATIENT'S CONDITION RELATED TO:

[redacted]

9. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 08 14 14 SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME: RETIRED

c. EMPLOYER'S NAME OR SCHOOL NAME: RETIRED

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE PART B CLAIMS

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12/05/02

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL DRESS, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D83074

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 185
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 08 02		3	1	99212		1	40.00	1.0				
2 11 08 02		3	5	81000		1	20.00	1.0				
3 11 08 02		3	1	J9202		1	1275.00	3.0				
4 11 08 02		3	1	NDC00310096130 96400		1	55.00	1.0				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 043249509 SSN [ ] EIN [X]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1390.00

29. AMOUNT PAID: $ 1059.79

30. BALANCE DUE: $ 263.86

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J MICHAEL DECENZO, M.D

SIGNED 12/05/02 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

(413) 784-5000
PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR.DR. STE 300
SPRINGFIELD MA 01107-1280

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: MI6033
CHECK/EFT #:126176362 11/26/02

126176362 100DD0268
PIONEER VALLEY UROLOGY PC
PAGE #: 9 OF 10

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]											
J08438	1111 111102	11	1	99212		40.00	38.68	0.00	7.74	CO-42 1.32	30.94
PT RESP	7.74			CLAIM TOTALS		40.00	38.68	0.00	7.74	1.32	30.94
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											30.94 NET
[redacted]										ICN 020231831860 ASG Y MOA MA01	MA19
M51618	1108 110802	11	1	99212		40.00	38.68	0.00	7.74	CO-42 1.32	30.94
M51618	1108 110802	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
M51618	1108 110802	11	3	J9202		1275.00	1275.00	0.00	255.00		1020.00
M51618	1108 110802	11	1	96400		55.00	5.60	0.00	1.12	CO-42 49.40	4.48
PT RESP	263.86			CLAIM TOTALS		1390.00	1323.65	0.00	263.86	66.35	1059.79
											1059.79 NET
[redacted]											
M51618	1108 110802	11	1	99213		60.00	53.55	0.00	10.71	CO-42 6.45	42.84
M51618	1108 110802	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
PT RESP	10.71			CLAIM TOTALS		80.00	57.92	0.00	10.71	22.08	47.21
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											47.21 NET
[redacted]											
J05335	1112 111202	11	1	99212		40.00	38.68	0.00	7.74	CO-42 1.32	30.94
J05335	1112 111202	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
PT RESP	7.74			CLAIM TOTALS		60.00	43.05	0.00	7.74	16.95	35.31
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											35.31 NET
[redacted]										MA18	
H21069	1111 111102	22	1	52000		300.00	105.09	0.00	21.02	CO-86 194.91	84.07
H21069	1111 111102	22	1	51705	51	120.00	32.78	0.00	6.56	CO-86 54.44	26.22
										CO-59 32.78	
PT RESP	27.58			CLAIM TOTALS		420.00	137.87	0.00	27.58	282.13	110.29
											110.29 NET
[redacted]											
J05335	1112 111202	11	1	99213		60.00	53.55	0.00	10.71	CO-42 6.45	42.84
J05335	1112 111202	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
PT RESP	10.71			CLAIM TOTALS		80.00	57.92	0.00	10.71	22.08	47.21
											47.21 NET
[redacted]											
M51618	1108 110802	11	1	99213		60.00	53.55	0.00	10.71	CO-42 6.45	42.84
M51618	1108 110802	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
PT RESP	10.71			CLAIM TOTALS		80.00	57.92	0.00	10.71	22.08	47.21
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											47.21 NET
[redacted]											
J05335	1108 110802	11	1	87184		25.00	9.53	0.00	0.00	CO-42 15.47	9.53
PT RESP	0.00			CLAIM TOTALS		25.00	9.53	0.00	0.00	15.47	9.53
											9.53 NET
[redacted]											
J05335	1111 111102	11	1	99213		60.00	53.55	53.55	0.00	CO-42 6.45	0.00
J05335	1111 111102	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
J05335	1111 111102	11	1	87088		30.00	11.18	0.00	0.00	CO-42 18.82	11.18
PT RESP	53.55			CLAIM TOTALS		110.00	69.10	53.55	0.00	40.90	15.55
											15.55 NET
[redacted]											
J05335	1112 111202	11	1	99213	25	60.00	53.55	0.00	10.71	CO-42 6.45	42.84
J05335	1112 111202	11	1	52000		300.00	217.89	0.00	43.58	CO-42 82.11	174.31
J05335	1112 111202	11	1	81000		20.00	4.37	0.00	0.00	CO-42 15.63	4.37
J05335	1112 111202	11	1	A4550		80.00	0.00	0.00	0.00	CO-B15 80.00	0.00
REM: M80											
PT RESP	54.29			CLAIM TOTALS		460.00	275.81	0.00	54.29	184.19	221.52
											221.52 NET
[redacted]										MA18	
A30989	1106 110602	21	1	99253		140.00	98.52	0.00	19.70	CO-42 41.48	78.82
PT RESP	19.70			CLAIM TOTALS		140.00	98.52	0.00	19.70	41.48	78.82
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											78.82 NET
[redacted]											
H21069	1108 110802	21	1	99252	25	120.00	72.19	0.00	14.44	CO-42 47.81	57.75
H21069	1108 110802	21	1	53670		135.00	26.49	0.00	5.30	CO-86 108.51	21.19
PT RESP	19.74			CLAIM TOTALS		255.00	98.68	0.00	19.74	156.32	78.94
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											78.94 NET

EMPLOYEE	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
REDACTED		E
PROVIDER TAX I.D. #:	PATIENT ACCOUNT #	40
043249509	51943	

97-4
040

No 0760893

07/01/2003
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY ********271DOLLARS AND 43CENTS** DOLLARS $ ****271.43**

TO THE ORDER OF

PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR DR
STE 308
SPRINGFIELD , MA 01107

0760893

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37230

⑈00760893⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
05/14/2003	05/14/2003	1410.00	.00	271.43	271.43	271.43
		1410.00	.00	271.43	271.43	271.43

NON-COVERED CODES:

COMMENTS:

REDACTED

REDACTED

PROVIDER: PIONEER VALLEY UROLOGY PC
PARTICIPANT SSN: DEPENDENT: :01
CLV CLAIM NUMBER: 2195072

SPRINGFIELD MA 01101

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

APPROVED OMB-0938-0008

SHEET METAL WORKERS
NATIONAL HEALTH TURST FD.
P.O. BOX 1449
GOODLETTSVILLE TN 37070-1

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

CHAMPVA (Member #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER [X] (ID)

1 IN ITEM 1 [X]

3. PATIENT'S BIRTH DATE: MM 08 DD 14 YY 14 — SEX: M [X] F [ ]

4

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7

PATIENT INFORMATION		INSURED INFORMATION	
CITY	STATE	CITY	STATE
SPRINGFIELD	MA	SPRINGFIELD	MA
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)	
01104		01104	

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES [ ] NO [X]
b. AUTO ACCIDENT? PLACE (State): YES [ ] NO [X]
c. OTHER ACCIDENT? YES [ ] NO [X]

RETIRED

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE PART B CLAIMS

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06/03/03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DANIEL DRESS, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: D83074

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: .00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 185
2.
3.
4.

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 14 03		3	1	99213		1	60 00	1.0				
2 05 14 03		3	1	J9202		1	1275 00	3.0				
3 05 14 03		3	1	NDC00310096130 96400		1	55 00	1.0				
4 05 14 03		3	5	81000		1	20 00	1.0				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 043249509 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 51943

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 1410.00

29. AMOUNT PAID: $ 1090.15

30. BALANCE DUE: $ 271.43

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
MARYANNE O'TOOLE, GNP
SIGNED 06/03/03 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIONEER VALLEY UROLOGY PC
2 MEDICAL CTR.DR. STE.308
SPRINGFIELD MA 01107-1280
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M16033
CHECK/EFT #:126637328 05/30/03

126637328 100000242
PIONEER VALLEY UROLOGY PC
PAGE #: 8 OF 10

MEDICARE REMITTANCE NOTICE

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
J08438	0512 051203 11		1	99215		60.00	54.41	0.00	10.88 CO-42	5.59	43.53
J08438	0512 051203 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	10.88			CLAIM TOTALS		80.00	58.84	0.00	10.88	21.16	47.96
											47.96 NET
A30989	0513 051303 11		1	99212		40.00	38.89	0.00	7.78 CO-42	1.11	31.11
A30989	0513 051303 11		3	J9202		1275.00	1275.00	0.00	255.00		1020.00
A30989	0513 051303 11		1	96400		55.00	42.23	0.00	8.45 CO-42	12.77	33.78
PT RESP	271.23			CLAIM TOTALS		1370.00	1356.12	0.00	271.23	13.88	1084.89
											1084.89 NET
J05335	0515 051503 11		1	99212 25		40.00	38.89	0.00	7.78 CO-42	1.11	31.11
J05335	0515 051503 11		1	52000		300.00	267.94	0.00	53.59 CO-42	32.06	214.35
J05335	0515 051503 11		1	A4550		80.00	0.00	0.00	0.00 CO-B15	80.00	0.00
REN: M80											
J05335	0515 051503 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	61.37			CLAIM TOTALS		440.00	311.26	0.00	61.37	128.74	249.89
CLAIM INFORMATION FORWARDED TO: MAT ASSOC OF LETTER CARRIER											249.89 NET
J05335	0513 051303 11		1	99213 25		60.00	54.41	0.00	10.88 CO-42	5.59	43.53
J05335	0513 051303 11		1	51702		125.00	101.26	0.00	20.25 CO-42	23.74	81.01
J05335	0513 051303 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	31.13			CLAIM TOTALS		205.00	160.10	0.00	31.13	44.90	128.97
											128.97 NET
[illegible]	0513 051303 11		1	99212		40.00	38.89	0.00	7.78 CO-42	1.11	31.11
PT RESP	7.78			CLAIM TOTALS		40.00	38.89	0.00	7.78	1.11	31.11
											31.11 NET
NAM					ACNT 51943C0501H7		ICN	0203139285830	ASG Y	MOA MA01 MA19	
MP0166	0514 051403 11		1	99213		60.00	46.25	0.00	9.25 CO-42	13.75	37.00
MP0166	0514 051403 11		3	J9202		1275.00	1275.00	0.00	255.00		1020.00
MP0166	0514 051403 11		1	96400		55.00	35.90	0.00	7.18 CO-42	19.10	28.72
MP0166	0514 051403 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	271.43			CLAIM TOTALS		1410.00	1361.58	0.00	271.43	48.42	1090.15
											1090.15 NET
[illegible]	0514 051403 11		1	99212		40.00	38.89	0.00	7.78 CO-42	1.11	31.11
M51618	0514 051403 11		1	51798		100.00	21.95	0.00	4.39 CO-42	78.05	17.56
PT RESP	12.17			CLAIM TOTALS		140.00	60.84	0.00	12.17	79.16	48.67
											48.67 NET
J05335	0512 051203 11		1	99213		60.00	54.41	0.00	10.88 CO-42	5.59	43.53
J05335	0512 051203 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	10.88			CLAIM TOTALS		80.00	58.84	0.00	10.88	21.16	47.96
											47.96 NET
MP0166	0512 051203 11		1	99213		60.00	46.25	0.00	9.25 CO-42	13.75	37.00
MP0166	0512 051203 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	9.25			CLAIM TOTALS		80.00	50.68	0.00	9.25	29.32	41.43
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											41.43 NET
J05335	0515 051503 11		1	99212 25		40.00	38.89	0.00	7.78 CO-42	1.11	31.11
J05335	0515 051503 11		1	52000		300.00	267.94	0.00	53.59 CO-42	32.06	214.35
J05335	0515 051503 11		1	A4550		80.00	0.00	0.00	0.00 CO-B15	80.00	0.00
REN: M80											
J05335	0515 051503 11		1	81000		20.00	4.43	0.00	0.00 CO-42	15.57	4.43
PT RESP	61.37			CLAIM TOTALS		440.00	311.26	0.00	61.37	128.74	249.89
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											249.89 NET
620018	0513 051303 11		1	87184		25.00	9.63	0.00	0.00 CO-42	15.37	9.63
PT RESP	0.00			CLAIM TOTALS		25.00	9.63	0.00	0.00	15.37	9.63
											9.63 NET

JUN 3 2003 JUN 12 2003

HIGHLY CONFIDENTIAL
SMWMASS 001434